

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030861

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1022

Registrar's No. 4548

VS 300
Rev. 4/59

1

2 3538

3

4 1

5 3

6

7 1

8 2

9 581.0

10

11

12 57.0

13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

E. Frank Ellis

1. PLACE OF DEATH
a. COUNTY Jacksonb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Kansas CityLength of stay in 1b
20 yrs.c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION General HospitalInside Limits
Yes ☐ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSONc. CITY OR TOWN KANSAS CITY
Inside Limits
Yes ☒ No ☐d. STREET ADDRESS 3818 Paseo
Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) Agnes Helen Brown

4. DATE OF DEATH September 3, 1962

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐
Widowed ☐ Divorced ☒

8. DATE OF BIRTH 9-13-1911

9. AGE (last birthday) 50

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK

10b. KIND OF BUSINESS OR INDUSTRY CROWN DRUG CO.

11. BIRTHPLACE (City and state or country) KANSAS CITY KANSAS

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME

BARLOW BROWN

13b. MOTHER'S MAIDEN NAME

MAY O NEIL

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO.

17. INFORMANT MRS. MAY BROWN 3818 PASEO K.C. MO.

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8-23-62 11:00 P to 9-3-62 and last saw her alive on 9-3-62
Death occurred at P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

2400 Cherry

22c. DATE SIGNED

9-5-62

23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

23b. DATE

9-6-62

23c. NAME OF CEMETERY OR CREMATORY

CALVARY CEMETERY

23d. LOCATION (City, town, or county)

KANSAS CITY MISSOURY

24. FUNERAL DIRECTOR

ADDRESS

SHEIL FUNERAL HOME K.C. MO.

25. DATE RECD. BY LOCAL REG.

9-5-62

26. REGISTRAR'S SIGNATURE

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas A. Sheil

Licensed Embalmer No. 4954

P. O. Address K. C. MO.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.